Save the Children Federation, Inc.

Child Survival 15 - Third Annual Report

The Partnership for Equity, Access and Quality (PEAQ) Project

Balaka District, Malawi
30 September 1999 – 30 September 2003

Cooperative Agreement Number FAO 00-99-00050-00

Written by:

Catherine Chipazi, PEAQ Coordinator, SC Malawi
David Patterson, Senior Health Advisor, SC Malawi
Eric Swedberg, Child Survival Specialist, SC

1 Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change and Communication
BCCC	Behavior Change and Communication Coordinator
BCG	Bacillus Calmette-Guerin
BF	Breastfeeding
CAC	Community AIDS Committee
CBD	Community Based Distribution
CBDA	Community Based Distribution Agent
CFPSP	Core Family Service Provider
CHAM	Christian Health Association of Malawi
CHAPS	Community Health Partnerships
CO	Clinical Officer
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DAC	District AIDS Coordinator
DACC	District AIDS Coordination Committee
DEC	District Executive Committee
DEHO	District Environmental Health Officer
DHC	District Health Coordinator
DHO	District Health Officer
DHMT	District Health Management Team
DHSA	District Health Services Administrator
DO	Data Officer
DPHN	District Public Health Nurse
DPT	Diphtheria, Pertussis and Tetanus
DRF	Drug Revolving Fund
DRFC	DRF Coordinator
DRHC	District Reproductive Health Coordinator
EBF	Exclusive Breastfeeding
EBFC	Exclusive Breastfeeding Coordinator
EHO	Environmental Health Officer
EPIC	Expanded Program of Immunization Coordinator
EPMU	Expanded Program Management Unit
HBC	Home Based Care
HC	Health Center
HCI/C	Health Center in Charge
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
KAP	Knowledge, Attitude and Practice Survey
KPC	Knowledge, Practice and Coverage Survey

MA	Medical Assistant
MCH	Maternal and Child Health
MIM	Malawi Institute of Management
MOHP	Ministry of Health and Population
NGO	Non-Governmental Organization
PC	Project Coordinator
PMU	Project Management Unit
PSI	Population Services International
QA	Quality Assurance
QAC	Quality Assurance Coordinator
QAP	Quality Assurance Project
SC/US	Save the Children Federation Inc., USA
SHA	Senior Health Advisor
SM	Safe Motherhood
STI	Sexually Transmitted Infection
STIC	Sexually Transmitted Infection Coordinator
TBA	Traditional Birth Attendant
TBAC	Traditional Birth Attendant Coordinator
TOT	Trainer of Trainers
TFT	Training for Transformation
URC	University Research Cooperation
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
ZC	Zone Coordinator

Introduction

Partnership for Equity, Access and Quality (PEAQ) is a USAID/Washington funded project of Save the Children Federation. Inc (SC/US) in partnership with the Balaka district health office (BDHO), which responds to the needs and priorities of constituent communities, the Ministry of Health and Population (MOHP), NGO partners, and USAID/Malawi, in seeking reduced under five and maternal mortality and morbidity through a strengthened health system. PEAQ seeks to:

- achieve a sustainable reduction in infant, child, and maternal mortality and morbidity;
- expand and refine a credible, demonstrably successful, efficient model for health system strengthening, that builds district-level capacity linking DHMT and key partners to ensure access, coverage, and quality; and
- adapt a district-to-district variation of the Living University (LU) model for replication, with one district serving as a "campus" for another.

Major interventions support the MOHP district-level essential health package and include: Immunization; Breastfeeding Promotion; Control of Diarrheal Disease; Control of Malaria; Case Management; Newborn Care; Child Spacing; and STI/HIV/AIDS Prevention. All interventions are consistent with MOHP policy.

Key implementation strategies include:

- Partnering and institutional development (P/ID).
- District-level replication through Living University (LU) approach;
- Health System Strengthening (equity, access, availability, quality of care) through: (1) the District Health Management Team (DHMT); (2) Quality assurance (QA) teams functioning at district and facility levels with the engagement of community members.
- Strengthening the community component of health delivery (demand, access, caretaker practices) through: (1) Village Health Committees (VHCs); (2) Drug Revolving Funds (DRFs); (3) Alarm and transport plans; (4) Bicycle ambulances; (5) Trained community-based providers (HSAs, CBDAs, TBAs); (6) Engagement of traditional practitioners (healers, Initiation Counselors); (7) A carefully designed behavior change communication (BCC) package targeting caretakers, community "gatekeepers" and male decision-makers.
- Operational research (OR) to test methods that support the community component of IMCI (e.g., collaboration with Traditional Healers and Initiation Counselors) and Maternal Newborn Care (e.g., birth plans).

The Balaka District Health Management Team (DHMT) is the main implementer of the project interventions while SC/US provides capacity-building, technical assistance, management support, and has the fiduciary responsibility. Other key collaborating partners include, Maphunziro Foundation, Christian Service Committee, Muslim Association of Malawi, and Evangelical Baptist Church of Malawi.

The CS-15 beneficiary population is estimated at 43,275 children 0-59 months[1] and 92,299 women of reproductive age[2]. Staff members of the 9 health centers and the district hospital are also beneficiaries of PEAQ activities. The project was started in October 1999 and is scheduled to end in September 2003. This report covers the third year of project implementation, from 1 October 2002 to 30 September 2002

[1] Children under five comprise 17.3% of the total population (MKAPHS 1996).
[2] Women of reproductive age comprise 23.3% of the total population, based on 1996 DHS

Table A: Achievement of Objectives[3]						
		BASE-LINE	Mid-term	Final	Progress Satisfactory	Comments
	IMMUNIZATION					
1	Percent of children age 12-23 months fully immunized by their first birthday	46%	60%	75%	YES	
2	Percent of mothers of children age =< 24 months who received 2 or more doses of tetanus toxoid during their last pregnancy	80%	85%	90%	YES	
3	Percent of children age 6-24 months who received Vit A in the six months prior to the survey	10%	46%	40%	YES	
	Breastfeeding Promotion					
4	Percent of children who received only breast milk up to at least 4 months of age	10%	68%	20%	YES	Initial estimates of a feasible objective were superseded by midterm. This is attributed to improvements in maternity discharge counseling.

[3] Please note that the methodology used for the baseline survey was a 30-cluster survey methodology, while the mid-term evaluation survey utilized an LQAS methodology. When the data was analyzed, it was learned that insufficient data had been obtained for certain indicators due to the small LQAS sample size. We are therefore unable to comment on the progress of these indicators.

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
	Maternal and Newborn Care					
5	Percent of mothers with children age =< 24 months who received iron/folate supplementation during their last pregnancy	66%	77%	80%	YES	
6	Percent of mothers with children age 24 months or under who received at least one dose of Fansidar during their last pregnancy	68%	63%	80%	NO	
7	Percent of mothers with children age 24 months or under who report last delivery assisted by a health worker or trained TBA	64%	70%	75%	YES	
	Child Spacing					
8	Percent of married women 15-49 years old using modern contraceptives	21%	18%	30%	NO	

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
	STI/HIV/AIDS Prevention					
9	Percent of women 15-49 years old who report condom use with non-regular partner	26%	NA	50%	NA*	* Mid term evaluation sample too small to evaluate this indicator
10	Percent of women 15-49 years old who know of three ways to prevent STI/HIV	13%	16%	60%	NO	
11	Percent of men 15-54 years old who report condom use with non-regular partner	50%	NA	70%	NA*	*Mid term evaluation sample too small to evaluate this indicator
12	Percent of men 15-54 years old who know of three ways to prevent STI/HIV	19%	29%	60%	YES	
13	Percentage of female youth 15-19 years who delay sexual debut	20%	NA	30%	NA*	* Mid term evaluation sample too small to evaluate this indicator
14	Percentage of male youth 15-19 years who delay sexual debut	21%	NA	30%	NA*	*Mid term evaluation sample too small to evaluate this indicator
15	Number of persons tested in VCT centers/month	0	8	350	NO	

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
16	Per cent of target OVC with access to community services (OVC program)	0	NA	50%		PEAQ has begun to work on this through the new Adopt-A-Village program (funded externally).
17	% of households receiving help in caring for chronically ill young adults (15-49) in a population survey	0	NA	50%		A Home-Based Care program has begun operating in the District.
18	% STI cases treated according to national standards (STI treatment protocols)	0	NA	50%		
	Control of Diarrheal Disease					
19	Percent of children age 24 months or under who have had diarrhea in the last two weeks prior to the study		41%			
20	Percent of children age 24 months or under who have had diarrhea in the two weeks prior to the survey and who have been treated with Oral Rehydration Therapy (ORT)	67%	59%	80%	NO	Please see text below.
21	Percent of children age 24 months or under presenting at health facility with diarrhea who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	59%	NA %	80%	NA*	* These standards incorporated into IMCI. IMCI not yet implemented in Balaka

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
	Control of Malaria					
22	% of children 24 mo or under with fever in the two weeks prior to the survey		50%			
23	Percent of children age 24 months or under with fever in the two weeks prior to the survey who obtained medical care from a health facility	33%	40%	50%	NA*	* Mid term evaluation sample too small to evaluate this indicator
24	Percent of children age 24 months or under presenting at health facility with fever who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	44%	NA %	70%		Awaits implementation of IMCI.
	Pneumonia Case Mgmt.					
25	Percent of children 24 mo or under with cough and difficult/rapid breathing in the two weeks prior to the survey		5%			
26	Percent of children age 24 months or under with cough and difficult/rapid breathing in the two weeks prior to the survey who obtained medical care from a health facility	46%	37%	80%	NO	Please see comments on BCC strategy revision, in text below.
27	Percent of children age 24 months or under presenting at health facility with cough and difficult/rapid breathing who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	44%	NA	70%		Awaiting implementation of IMCI

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
	DHMT SUSTAINABILITY					
28	50% of villages have formal alarm and transport plans	0	59%	50%	YES	
29	80% of women delivered by trained TBAs in villages with alarm and transport system use it	0	NA*			
30	80% of DHMT meetings discuss current HMIS information and make management decisions based on the data	0	50%	80%	YES	
31	Each of the 9 trained HC QA teams investigate and solve at least 3 problems per year after training	0	4 trained	9	NO	
32	A Functioning DHMT-NGO District Coordination Comm. (DHPCC)	NO	Yes	Yes	YES	
33	A District Fundraising Committee established and mobilizes resources for at least 2 projects per year	NO	NO	YES	NO	
34	Quarterly HMIS report produced and disseminated using computerized HMIS data	NO	YES	YES	YES	
35	80% of villages with functioning VHCs i.e. VHCs meeting at least one every two months (6 times/year)	0%	63%	80%	YES	

	INDICATORS	BASE-LINE	MID-TERM	Final	Progress Satisfactory	Comments
	OPERATIONS RESEARCH					
36	Documented results of working with Traditional Healers and initiation leaders	NO	NO	YES	NO	
37	Document results of Living University Approach	NO	NO	YES	NO	Rikki Welch of CSTS is assisting SC document this experience.
38	Document Results of Birth Plan Use	NO	YES	YES	YES	

B. Objectives and Constraints

1. **Objective**: Percent of mothers with children age 24 months or under who received at least one dose of Fansidar during their last pregnancy. The percentage of mothers receiving Fansidar has dropped from 68% to 63%

   Constraint: The MOHP drug logistics system delivers insufficient amounts of fansidar to clinics and health centers.

   Proposed Action: The project will investigate the causes of this failure on the part of the drug logistics system to deliver sufficient quantities of Fansidar to clinics and health centers. Solutions will be developed based upon the findings.

2. **Objective:** Percent of married women 15-49 years old using modern contraceptives. The percentage of women using contraception has remained the same or dropped slightly.

   Constraint: Injectable contraception is the preferred method of women in the project area. In the original project design, HSA were permitted to provide this method at the community level. A subsequent policy decision by the MOHP to disallow the delivery of this method by HSA effectively eliminates injectables at the community level resulting in stagnant contraceptive prevalence. There is insufficient staff to implement community outreach clinics.

   Proposed Action: The project has trained more CBDAs to improve access to other methods. Renewed emphasis is being placed on alternative methods including oral contraceptives and the use of condoms for contraception. Staffing constraints cannot be directly addressed, but the project supports outreach clinics by providing transport and assisting with scheduling.

3. **Objective**: Percent of women 15-49 years old who know of three ways to prevent STI/HIV. The percentage had increased by the mid-term, but only by 3%.

   Constraint: The percentage of women who can identify means to protect themselves from contracting STIs remains virtually unchanged from the baseline.

   Proposed Action: The project is currently revising and reprioritizing its BCC strategy. A special focus will be put upon working with this audience to ensure that these messages are delivered to them as part of an effective BCC strategy.

4. **Objective:** Number of persons tested in VCT centers/month. Numbers of people tested at VCT centers remains low.

Constraint: The VCT center in Balaka district is not well established. It lacks furniture and equipment and the center frequently runs out of testing reagents . Community sensitization to encourage use of the VCT clinics has not been extensively carried out resulting in low awareness and demand.

Proposed Action: We will provide the reagents for ELIZA testing in the short term and in the longer term the project will provide training for lab personnel in the use of rapid test kits. These will also be provided. The MOHP BCC and HIV coordinators will work with the Project to undertake community sensitization to improve demand for these services. Necessary equipment will be provided.

5. **Objective**: Percent of children age 24 months or under who have had diarrhea in the two weeks prior to the survey and who have been treated with Oral Rehydration Therapy (ORT). The percentage of mother's reporting the use of ORT during a diarrheal episode appears to have declined since the baseline. This may be an artifact of measurement (there were significant differences in the posing of this question in the two surveys).

   Constraints: BCC has not been sufficiently effective.

   Proposed Action: The project is addressing this issue in the context of its ongoing revision of its BCC strategy.

6. **Objective:** Percent of children age 24 months or under with cough and difficult/rapid breathing in the two weeks prior to the survey who obtained medical care from a health facility. The target percentage was not reached, and in fact there was a slight decline from the baseline percentage.

   Constraints: BCC has not been sufficiently effective.

   Proposed Action: The project is addressing this issue in the context of its ongoing revision of its BCC strategy.

7. **Objective:** Each of the 9 trained HC QA teams will investigate and solve at least 3 problems per year after training.

   Constraint: Only four QA teams have been trained to date. Those that have been trained continue to require extensive technical support. Staff turnover in the project has made it difficult to provide that support and as a result, progress has been slowed. Two SC trainers have been lost in the last year, only one of whom has been replaced. The new trainer hired for the project does not have QA qualifications Although, two government counterparts have been trained, they are not active. One has transferred to another program and the other lacks sufficient support from his colleague to be active.

   Proposed action: Expertise remaining with the government partner will be utilized. With the assistance of the government partners the Project trainer will be trained in QA so that she may, in turn, provide technical support and

training to other government partners in QA. This will allow the reestablishment of QA expertise within the project and permit ongoing support to the government.

8. **Objective**: A District Fundraising Committee be established and mobilize resources for at least 2 projects per year.

   Constraint: This committee has not been organized by the PMU.

   Proposed action: The PMU has decided that the existence of such a committee is redundant due to the creation of the District Assembly. It is the responsibility of this body to raise funds for all district government functions. This body has already carried out fundraising activities for the benefit of the health sector. No action needs to be taken by the Project.

9. **Objective:** Document results of working with Traditional Healers and Initiation Counselors.

   Constraint: It was decided by the midterm evaluation team to give a low priority to the training of traditional healers. It is likely that this will not be undertaken in this project funding cycle. Initiation counselor training began in 2001.

   Proposed action: The training of Initiation Counselors has been documented in training reports. These will be circulated within the project, its partners and other Save the Children projects. When these activities are evaluated, reports and lessons learned will be promulgated within Save the Children, to its partners and to the larger development community.

C. Technical Assistance Plan for Year 4

INTERVENTION/TYPE OF ASSISTANCE	SOURCE	SCHEDULE	CONSULTANT
BF Promotion			
BF Promotion	MDHO MWFO SC/US Africa Regional Office	January 2002 – March 2003	Mangochi BF Coordinator David Patterson Joseph de Graft-Johnson
STI/HVI/AIDS			
Development of district HIV/AIDS strategies	SC/US COPE Project	June 2002 – June 2003	Mangochi COPE District Coordinator and Economic Opportunities Officer
Workplan and Evaluation			
Final evaluation	SC/US MWFO SC/US Africa Regional Office SC/US Home Office	August – September 2003	External consultant David Patterson Joseph de Graft-Johnson Eric Swedberg

D: DIP modifications:

There are no substantial changes to the program description and DIP that require a modification of the Cooperative Agreement.

E. Mid term evaluation recommendations

The CS15 Partnership for Equity Access and Quality (PEAQ) Child Survival Project underwent its mid term evaluation between January 21-31, 2002 in accordance with USAID requirements. This delay was a product of the events of September 11, 2001. The team, which was led by an external evaluator and made up of Save the Children staff, MOHP national level staff and MOHP district level staff, assessed the Project progress to date as well as its strengths and challenges. The evaluation team leader made a series of recommendations for strengthening the project in its remaining two years. In response to these recommendations, the Project Management Unit of CS 15 in collaboration with members of the Extended PMU (including program coordinators, zone coordinators, clinic staff and other stake holders) have developed an action plan to address the recommendations made in the mid term evaluation. This plan was completed and submitted in June 2002 although activities were initiated prior to its submission. *Given the short period of less than 3 months between the completion of the action plan and the due date for the submission of the third annual report, it has not yet been possible to undertake all planned activities. Updates are provided where the status of an activity has changed since the formulation of the Action Plan.*

Overarching Recommendations

In the section below, the recommendation, the proposed action outlined in the action plan, and the current status of that action are reviewed.

Responses to the Overarching Recommendations

- Taking the midterm results and recommendations into account, the expanded PMU (EPMU) should do a strategic review of the program in relation to its coverage/allocation of resources, and the time remaining. This should result in a revised and realistic plan for training, and reconsidered balance between training and implementation activities.

  ⇒ *The PEAQ CS15 Child Survival Project held a planning workshop with its partners on March 12, 13 and 14, 2002 to address the issues raised in the MTE, to identify and prioritize key activities for the second half of the project and to develop a realistic action plan for implementation. Responses to the detailed recommendations made by the MTE were developed at that time and may be found below.*

- New personnel in the district and SC should be seen as an opportunity to reestablish the commitment to partnership and mutual respect and trust at the central levels.

⇒ *During the post-MTE planning meeting, a sub-meeting of the PMU, including the new District Health Officer, the Save the Children Field Office Director (FOD) and the Save the Children Child Survival Specialist and the Senior Health Advisor was arranged. At this meeting, the terms of Reference that form the basis of cooperation between the MOHP and Save the Children at the district level was reviewed. Renewed commitment to the terms of reference was expressed by all parties.*

- The Project should develop a more participatory and systematic behavior change approach, focusing on the specific child survival behaviors and involving community members in identifying gaps between desired and actual practice.

⇒ *The original BCC strategy for the project was broad and lacked prioritization of key messages. The MTE found some successes in message delivery, but also notable areas that needed renewed emphasis. The planning meeting was utilized to develop a plan for revising the Project BCC strategy. PEAQ CS15 will review and revise its current BCC strategy using the BEHAVE Framework for BCC program planning. A BEHAVE Framework training workshop for CS15 staff and government counterparts is now in planning. In addition, PLA strategies such as GAPs analysis will be utilized to fully involve the community in the identification of key behaviors and areas upon which to concentrate.*

***Update**: After some delays caused by difficulties in coordinating the schedules of key participants in the redesign of the project BCC strategy, a BEHAVE workshop was held for EPMU members. This five day workshop, facilitated by the SHA and the project coordinator, reviewed all the child survival behaviors promoted by PEAQ. These were then classified into thematic areas such as MCH, FP, HIV/AIDS. Each theme group was used as the basis for a community based GAPS exercise. The EPMU was broken up into sub teams One theme was discussed per community and priority behaviors within that theme group were identified by each community . Because this prioritization activity was carried out in only one zone, with 4 communities, the EPMU feared that the findings could not be generalized to the district as a whole. Plans were accordingly made to carry out the same exercise in all the zones of the district. This plan is currently being implemented. After the completion of the district wide BEHAVE/GAPS exercise, a workshop will be held to discuss the findings and its implications for the BCC strategy. It is expected that the product of this exercise will be a comprehensive, reprioritized BCC strategy developed in collaboration with community members. This will then be implemented for the remaining communities.*

- The PMU is the essential forum for problem solving and establishing systems for the management of this Project. Using the Living University (LU) and other resources, the management skills of the unit should be actively developed.

⇒ *Although there is a regular and systematic exchange of program experience and lessons learned between CS15 and the CHAPS Project utilizing the Living University model, this will be expanded to provide a mechanism for imparting knowledge and experience in management and supervision gained by the CHAPS PMU. Senior government and Save the Children staff from the CHAPS PMU will be invited to visit CS15 to meet with the CS15 PMU. The purposes of the meeting will be to arrange formal workshops and presentations on specified topics, and also to participate in on the job trainings sessions.*

Update: *These issues are on the agenda for discussion at the CHAPS annual retreat to be held in November 2002.*

Action plan for Specific MTE Recommendations

MATERNAL NEWBORN HEALTH

- TBA training should include an emphasis on recognition of danger signs, early referral, and birth planning.

⇒ *TBAs scheduled for initial training will have danger signs and birth planning included in their curriculum. Trainers will be briefed on this revision in the curriculum.*
⇒ *All other trained TBAs will be refreshed and the training will include danger signs and birth planning in the curriculum.*

Update: *Training of new TBAs has been removed from the work plan of PEAQ due to its high cost. Beginning in April 2002, however, training on danger signs and birth plans has been incorporated into the syllabus for refresher trainings for trained TBAs. Of the 85 trained TBAs in the district, a total of 66 TBAs have been refreshed since April 2002. The rest are due for refresher course in the third quarter of 2003.*

- The whole community should be involved in the early recognition and referral of danger signs. This is part of the alarm and transport system.

⇒ *VHCs will educate communities during village meetings on early referral and recognition of danger signs.*

Update: *The failure of communities to recognize the danger signs came through strongly in the GAPS exercise. This problem was recognized by communities and prioritized. Doer/Non-doer analysis is being conducted to identify constraints and benefits that may be utilized in developing an effective BCC program. The findings of a recent study on cultural constraints to birth planning in the district will also be utilized to improve the recognition of danger signs and encourage birth planning.*

- TBAs should be encouraged to come into the HC once per month for continuing education, reinforcement of skills, and strengthening of the referral relationship. Program Coordinators should work with Zone Coordinators (ZCs) to make it possible for HC staff to supervise TBAs in the community periodically. Resupply can occur during monthly visits, or with the help of the ZCs during the rainy season. ZCs should work with communities to supervise TBAs with respect to infection prevention.

  ⇒ *Health Centers will, with assistance from the TBA Coordinator, incorporate monthly and quarterly TBA visits to the health facility and TBAs respectively on their workplans. Health center staff will be oriented on TBA supervision.*

  Update: *The TBA coordinator has oriented health center staff to TBA supervision and as of the June 2002, this responsibility has been assumed by the health center level. The PMU meeting in October 2002 revealed that not all health centers have been successful in undertaking this. The TBA coordinator will provide additional technical support to health centers having difficulty undertaking this activity.*

- Incorporate a review of traditional harmful delivery practices and the reasons they are not changed as part of an overall community BCC strategy. (see recommendation under community mobilization/BCC section)

  ⇒ *After a "BEHAVE" workshop for EPMU members, zonal teams (comprising ZCs and HSAs) will conduct GAP analyses in all zones during PLA exercises and harmful delivery practices will be dealt with during the exercises and in the formulation of a BCC strategy. The SHA will be involved in the process.*

  Update: *See discussion above.*

- Maternal audits should include dialogue with the community where the death occurred, and action to address the causes should result.

  ⇒ *During maternal audits, maternal audit teams will be formed in all health facilities in the district. Communities where death occurred will be included in the enquiry. The Safe Motherhood Coordinator will supervise the audits.*

  Update: *The maternal death audit team has just been established for the district hospital. Plans for training maternal death audit teams in health centers have been incorporated into the work plans for the October to December 2002 quarter. Discussions of how best to include communities in the maternal death audit process are underway. It is expected that this issue will be addressed following the establishment of the health center teams.*

FAMILY PLANNING

- Management should map actual FP coverage in the district (where there are active providers), taking into account the CHAM HCs. Further training of providers as well as prioritization of areas to be served by outreach clinics should be planned to maximize access district-wide, taking advantage of the most active providers.

  ⇒ *Mapping for FP coverage will be conducted in the 2nd and 3rd quarter of 2002 by Zone Coordinators and HSAs. This will facilitate equitable distribution of services.*
  ⇒ *Active HSA providers will be encouraged and be given moral support in their work by their supervisors.*

Update: *Kalembo and Mbera zones have completed their mapping exercise. The other zones plan to do their mapping in the next quarter (Oct-Dec 2002).*

- ZCs should work with HC staff as a team to implement effective supply monitoring and ordering systems. They need to be trained to do this.

  ⇒ *Zone Coordinators and Health Center staff will be trained on the new FP logistic supply system. The FP Program Coordinator and FP trainers from Mangochi will facilitate the training.*

  Update*: Family Planning providers in all health facilities have been trained in the new Family Planning Guidelines. Zone Coordinators will be trained in the next quarter.*

- Integrate FP services with EPI/GM during outreach – encourage participation of HC staff and addition of ANC where possible, and/or have more than one HSA so core providers can also do FP activities.

  ⇒ *Transport will be provided for H/C nurses to go to outreach clinics. District staff will cover areas where health center staff cannot.*
  ⇒ *A mobile team of nurses and environmental health assistants will be formed to accompany HSAs on outreach clinics. The DNO will be responsible for organizing the mobile team.*

Update*: No substantial activities to report.*

- Where CBDAs are available, emphasis should be on providing them the necessary training and support to remain motivated. The HSA role might be more one of support than of FP provision in these cases.

  ⇒ *HSAs and/or HSA Supervisors will visit CBDAs every month for supervision and supply of contraceptives. The FP Program Coordinator will ensure an adequate and consistent supply of contraceptives to health centers.*

***Update**: Irregular supplies at the district hospital from medical stores has affected supply at health centers and community volunteers. It is expected that training in the new family planning logistics system will improve supplies at the periphery.*

- Emphasis on dual protection and the identification and management of side effects should be covered at all levels of FP provision.

  ⇒ *On supervision, FP providers and motivators will demonstrate knowledge of side-effects and of t he benefits of using condoms for dual protection. Supervisors will utilize the available FP checklist.*

***Update**: No substantial activities to report.*

CHILD HEALTH

- Given the shortage of time and the political constraints, it may not make sense for the project to try and take on IMCI training during this phase. The project should still, however, make a concerted effort to define and focus child health interventions and behavioral messages at the community level.

⇒ *As the evaluation recommended, the IMCI strategy will not be undertaken in this funding phase. PLA activities will be done at zone level to develop behavioral messages for child health.*

***Update:** See BCC discussion above.*

- Establish a task force (including ZCs and maybe HSAs) to review and standardize DRF implementation. They should draw on MH experience, but make sure the MH model is adapted to BK reality:
  - Selection criteria including distribution throughout the district
  - Resupply systems – including resupply in small quantities
  - Control systems and quality monitoring

  ⇒ *A DRF task force will be formed. Establishment and training of DRFs will commence using the MOHP manual and recommendations, and lessons learned from the Mangochi experience. DRF training will be done after a needs assessment and review of DRFs management in Mangochi.*

***Update:** A DRF task force was formed and visited Mangochi to review their experience. DRF training has since commenced using the MOHP manual and training the VHC members for five days.*

- As with FP supplies, ZCs should work with HCs to establish a buffer stock for vaccine supplies and to make appropriate and timely orders for supplies.

  ⇒ *Zone Coordinators will work with H/C trained EPI managers on vaccine logistics to ensure a consistent supply to the health centers.*

***Update**: No substantial activities to report.*

STI/HIV/AIDS

- The project will need to review its HIV/AIDS activities along with the rest of its activities to develop a reasonable work plan for the remainder of the project.

  ⇒ *During the planning workshop, the workplan for HIV/AIDS activities was reviewed and a new plan was developed for the rest of the program. Unimplemented activities were ranked and those with the highest ranks were prioritized for implementation. All Program Coordinators and Zone Coordinators were involved in the planning.*

  ***Update:** Zone Coordinators attended a Training for Transformation (TFT), a basic component of the COPE training package for preparing districts to implement the COPE strategy. Zone coordinators are now involved in the mobilization and training of CACs.*

- The project should reinforce the MOHP policy of providing the full package of essential medicines for syndromic STI treatment at the HC level. Reasons why the District feels its supply is inadequate should be addressed, as should the mechanism balancing access and charges in CHAM areas. The issue of treatment costs needs to be considered in light of VCT since access to symptom management should be a motivating factor for being tested.

  ⇒ *The district hospital will try to get the full package of essential medicines for syndromic STI treatment and will learn from Mangochi experience. The DHO will liase with the Pharmacy Assistant on the issue.*

***Update:** Discussions with the STI Coordinator during the most recent EPMU meeting suggests that current drug supplies are adequate and that sporadic problems are linked to late reporting and supply requests. Future STI trainings will lay greater emphasis on supply and logistics issues. CHAM representatives have requested that the government supply free drugs so that they may provide free treatment. This request is under consideration.*

- Adequate condoms at the District and community level should be ordered – even if it is through the family planning program.

  ⇒ *Adequate condoms will be ordered through both HIV/AIDS and FP programs and distribute together with FP supplies. Both the HIV/AIDS and FP Coordinator will be responsible for ordering condoms.*

***Update**: No substantial activities to report.*

COMMUNITY MOBILIZATION

- The approach at the community level should be reorganized, using a participatory community approach involving HSAs, VHCs, and other community members in reviewing the key child survival behaviors for health, identifying barriers to adopting them, and developing strategies for promoting them. The key, behaviorally oriented messages will need to be clarified at all levels in order for this to be possible.

  ⇒ *A participatory community approach will be implemented at the community level after PLA exercises and BEHAVE workshop.*

Update: *As discussed above, the BEHAVE workshop has been carried out in one zone and a district wide GAPS Analysis Exercise is ongoing. The community-level strategy will be fully reorganized after the completion of these exercises.*

- Zone teams should consider their available resources and develop realistic ways (not necessarily through incentives) to motivate their volunteers.

  ⇒ *Zone teams will provide motivation to their volunteers through regular contact and moral support. The Zone Coordinators will ensure support and motivation of the volunteers.*

Update: *During the development of the MTE action plan several incentives options were discussed by the EPMU to motivate volunteers. Recognition of volunteers through the provision of identification badges was put forward as a possible incentive for volunteers. The project has subsequently purchased badges for several classes of volunteer. This will allow a higher profile and greater recognition within the community.*

- Community volunteers should be issued practice aids and teaching materials to support their work. Many of these are actually available free through the health education office.

  ⇒ *Since most teaching materials have to be purchased and are now provided through concerned programs at MOHP, affordable practice aids and teaching materials will be purchased. An inventory of all available and required materials will be drawn by the BCC Coordinator.*

Update: *An inventory of available and required materials was drawn by the BCC Coordinator. Most of the materials proved to be very expensive to procure. Only those that the project can afford will be purchased.*

- In light of the new approach, the role of the VHC should be clarified to encompass all health activities, and not just water and sanitation.

  ⇒ *The role of the VHC in Child Survival activities will be emphasized during training and supervision. VHC trainers will be briefed on the issue.*

Update: *It is expected that the VHC will provide a major channel for implementation of the new BCC strategy.*

- At the managerial level, the assistance of CHAPS can and should be used more intensely to resolve several difficulties within the project.

⇒ *Visits to and from the CHAPS will be intensified and will focus on areas with problems. The DHC will be responsible in identifying the need for visits.*

Update: *CHAPS is currently providing technical support for the implementation of BFHI in facilities in the district and the lessons learned from the establishment of an integrated BFHI/PMTCT/Breastfeeding activity currently being implemented in Mangochi will be shared with PEAQ. The DRF training issue was resolved using CHAPS experience.*

- Management of DRFs and STI drugs are other areas where lessons might be learned from Mangochi's experience.

⇒ *Refer to DRF on Child Health and STI/HIV/AIDS.*

ZONE LEVEL MANAGEMENT

- The relationship between the HC staff, the ZC, and the HSAs are key for effective supervision district-wide. These should function as a team, with the ZC as the primary voice for administrative issues at the central level. The ZCs could also have a role in infection prevention for both the health centers and the TBAs.

  ⇒ *The role of the Zone Coordinator and Health Center in charge and their relationships to the HSA will be clarified during zonal meeting and job descriptions will be exchanged so that they know what each other's responsibilities are.*

Update*: No substantial activities to report.*

- Program Coordinators should periodically attend zone meetings for technical supervision of HC activities, and to provide updates. Ways to make these supervision visits more integrated should be explored. (e.g. PCs could inquire about other programs and relay the information to the appropriate PC if there is a problem)

  ⇒ *Zone Coordinators will invite Program Coordinators to zonal meetings depending on the agenda to intensify technical supervision. Invitation letters to zonal meetings will be sent to Program Coordinators by Zone Coordinators.*

Update*: No substantial activities to report.*

- Regular Zone Coordinator meetings with PCs at the central level are essential to assure connection between central management and implementation. These should be priority activities.

  ⇒ *Program Coordinators are being encouraged to hold regular meetings with Zone Coordinators. The meetings will continue to be part of the work plan.*

Update: *Program Coordinators now have regular quarterly contact with Zone Coordinators during Expanded Project Management Unit (EPMU) meetings. In addition, the project is promoting regular monthly meetings between Program and Zone Coordinators.*

- TBA supervision – see recommendation under maternal health section

  ⇒ *TBA supervision (Refer to MNC section)*

- The QA intervention should be well developed and successful in the four initial health centers before proceeding to others.

  ⇒ *The trained QA teams will be strengthened through regular supervision and should complete the problem solving process for at least 2 identified problems before proceeding to train other health centers.*

Update: *QA teams are still in the process of solving their first problem and need supervision from QA coaches. The Project trainer will be trained in QA so that she may, in turn, provide technical support and training to other government partners in QA*

CENTRAL DISTRICT MANAGEMENT

- The PMU is the primary forum for project problem solving, decision making, and development of management systems. As such, it should take one management topic at a time (e.g. supply distribution, essential drug management, transport management, audit and control systems, supervision) and work through the issues, barriers, and system solutions to managing them. This process should be seen as a learning opportunity and should be facilitated by SC staff, the Living University, and other technical resources for management strengthening. This is a practical way of doing management training.

  ⇒ *The PMU will meet regularly and whenever necessary to discuss and resolve issues. Supply distribution, essential drug management, transport management and supervision are some of the areas it will focus on.*

Update*: No substantial activities to report.*

- The PMU needs to immediately begin to work on a plan for moving SC responsibilities towards MOH in planning for sustainability.

  ⇒ *More responsibilities will continue to be moved towards MOHP to ensure sustainability.*

  ***Update**: Most of the planning activities and provision of various supplies has been shifted to MOHP. Two nurses are being upgraded to community nurses to take up the posts of two SC/US zone coordinators after the project phases out.*

- The PMU should work with PCs and ZCs on implementation issues such as human resource allocation, integration of supervision, systems for receiving and addressing field concerns, equal access (CHAM and MOH areas) to affordable AIDS case management and reliable supplies of STI drugs (HC) and condoms (HC and HSA)

  ⇒ *The PMU will work with Program Coordinators and Zone Coordinators in issues of staff deployment, supervision and logistics. The DHO is responsible for ensuring that this is done.*

***Update**: no substantial activities to report.*

- Communication of project objectives and management agreements and policies needs to occur reliably and transparently to all levels

  ⇒ *New MOHP staff will be oriented to project documents through their supervisors. Old staff will be encouraged by their supervisors to read their DIP document since it has policy and management agreements.*

  ***Update:** The project will review major documents, goals and objectives during the EPMU meetings.*

TRAINING

- HSAs need to be involved in the trainings of their community supervisees. This strengthens their knowledge, offers the opportunity for them to establish support relationships with their community workers, and can improve the trainer/trainee ratio if the HSAs are utilized as "co-trainers".

  ⇒ *Since HSAs have already been involved in training of community volunteers, more HSAs will be involved taking advantage of the active and able HSAs. However, some trainings e.g. CBDA and CMM for volunteers cannot be done by HSAs. Therefore HSAs will be involved as participant observers to facilitate supervision.*

  ***Update**: No substantial activities to report.*

- HC staff should be oriented to the training content and supervision needs of trainees under their oversight, but their direct involvement may be too resource intensive for the project to support.

    ⇒ *Orientation of HC staff on training content and supervision needs of trainees will continue to include all trainings at zonal level so that the staff are aware of what is happening in their area. HC with adequate staff can be given chances to facilitate trainings in their catchment area. ZC will ensure that HC staff are involved wherever possible.*

    ***Update**: No substantial activities to report.*

- All training staff should be well oriented in adult learning methodologies and participatory education approaches.

    ⇒ *Trainers will be oriented in adult learning methodologies and participatory education approaches.*

    ***Update:** All Zone Coordinators and the SC/US Health Trainer have been trained Training For Transformation, which includes approaches to adult education. Some HSAs who usually take part in training of community volunteers will undergo TFT in the next quarter.*

- Training should not take place (be postponed) unless the necessary supplies for their job can be provided by the end of the training.

    ⇒ *Materials and tools necessary for the use of skills and knowledge gained in training will be purchased before training takes place and provided at the time of training when possible.*

    ***Update:** No trainings requiring such preparation have been carried out to date.*

- Teaching aids and work aids should be used during training and made available for volunteers to use in the community.

    ⇒ *Refer to action under Community Mobilisation.*

HMIS/ADMINISTRATION

- Project staff should be involved with supporting the implementation of the new HMIS where possible, including assistance with completion and use of the monthly reports. They should document difficulties and concerns with the new system, using this information to advocate for adjustments where necessary.

⇒ *Project staff will be involved in implementation and monitoring of the new HMIS and make corrections where necessary. The DHO will ensure that this is done.*

***Update**: In the quarter following the completion of the action plan, sixty three support staff in the health facilities were oriented on the new HMIS. Orientation of all health personnel was done in the quarter just before the MTE exercise. The orientation included introduction to new forms, how to utilize them and use of the information at community and health center level. Additional training has been carried out in the third quarter.*

During HMIS supervisory visits the HMIS team identified some problems. Problems encountered include inaccurate recording of data, untimely reporting and a lack of delegation by in-charges. The problems were solved after frequent and regular supervision to the health centers.

- Discussion of maintenance priorities between the administrators of SC and MOHP, and more systematic handling of procurement requests and approvals might help facilitate logistics and vehicle support.

⇒ *The Assistant Administrative Officer will interact more with the MOHP hospital administrator on vehicle maintenance and logistics.*

***Update**: No substantial activities to report.*

F. DIP Phase Out Plan

The Phase Out Plan is on schedule in that devolution of activities to the District team has already begun. Instead of providing parallel services, the basic strategy of the PEAQ is to build the capacities of the health system to plan, implement, manage, monitor and evaluate essential primary health care services. Most project activities are conducted by District Health personnel after orientation and training by SCF/PEAQ.

G. Factors Positively or Negatively Impacting PEAQ

The following are the factors that have either limited or accelerated PEAQ's progress toward its goals and objectives:

1. High staff turnover within the Project. High staff turnover within the project was a major challenge faced by the project in the third year. Two project trainers left for higher posts within the organization and the Data officer left for studies in South Africa. The data officer and one trainer have been replaced.

2. The District Health Office remains understaffed and suffers from high staff turnovers.

3. Scheduling conflicts often interfere with project activities. Demands on DHO staff time is high. The MOHP and other NGOs implement activities in which DHO staff participate. Lack of coordination often results in scheduling conflicts resulting in low attendance or participation in project activities. The project will seek better coordination with the government and other NGOs.

4. PEAQ has benefited from the fact that SCF/US carries out a series of related projects (CHAPS, COPE, Saving Newborn Lives, etc.) in other districts of Malawi. The conjunction of PEAQ with these projects through the mechanism of the Living University has brought a level of experience and expertise to PEAQ that would be unavailable otherwise.

5. The partnership model with the District Health Management Team has been successful. Working relationships, particularly with the new DHO, are positive and productive.

H. New Methodology:

During the past quarter, the PEAQ project has initiated a new approach to designing behavior centered communication (BCC) in response to the mid-term evaluation's recommendations. Since the Senior Health Advisor and Project Coordinator had undergone training in the BEHAVE model, they were able to institute training in this model for District staff. BEHAVE is a program planning tool but it does not specify a particular methodology for eliciting community input into the design of BCC. The PEAQ project therefore employed an additional methodology that is based on the IMCI GAPS Analysis to enable the target communities to prioritize the behaviors and practices that are most in need of change. The GAPS method was used to identify a set of behaviors that the community members recognize as key to child survival but that are rarely practiced in the community. The identification of key behaviors by the community was then followed up by the BEHAVE model's doer-nondoer analysis to identify factors that influence the practice of these behaviors. The next step is to integrate these findings into the BEHAVE planning framework. This process is now underway. SCF/US feels that this combination of tools is a promising approach to the design of a behavior change strategy that incorporates the community point of view.